BENEFICIARY ISSUES IN MEDICARE REFORM

TESTIMONY BEFORE THE HOUSE BUDGET COMMITTEE

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July 25, 2001

Chairman Nussle, Congressman Spratt, and Members of the Committee: Thank you for the opportunity to testify today on Medicare reform issues. My testimony today examines the eight principles for reform of the Medicare program recently put forth by the Bush administration. These principles essentially raise four specific issues that I discuss below:

* The need for improved benefits, including prescription drugs;
* How the program should be structured in the future;
* How to strengthen the program's financial security; and
* Management and regulatory changes to improve the operation of the program.

More details on these principles are needed to understand the intent of the administration, but they do address the range of issues that need to be considered in reform. However, in much of the initial discussion of these principles, beneficiary concerns are raised mainly in the context of expanded coverage. But beneficiary concerns should be a part of each of the issue areas; indeed, the program is intended to aid seniors and persons with disabilities and that should be at the forefront of debate about Medicare's future.

Improved Benefits

The first two principles outlined by the Bush administration were for the *option* of a prescription drug benefit as part of a modernized Medicare, and for better coverage for preventive care and serious illnesses. Prescription drug coverage is a major concern and one on which there seems to be considerable agreement. However, this principle only promises an option for such coverage, implying that it would likely require an expensive premium contribution from beneficiaries and hence would not be universal. The second principle refers to coverage of certain screening and preventive services that could be further expanded, building on changes that have already been made in this area. But even more important, a goal of better coverage for serious illnesses refers to adding protections for beneficiaries who incur substantial expenses, usually done by placing a cap on total out-of-pocket spending (referred to as stop loss).

The inadequacy of Medicare's basic benefit package is now well known. Beneficiaries have had to scramble to fill in the gaps by supplementing Medicare with Medicaid, employer-sponsored insurance, Medicare+Choice enrollment, and/or private supplemental plans (Medigap). As a consequence, health care delivery for beneficiaries becomes complex and it is not always efficiently delivered since many of those with extra coverage have most of their cost sharing filled in as well. Further, those who rely on Medigap or who have no coverage experience very high out-of-pocket costs for meeting their health care needs.

It is not surprising, then, that proposals to reform Medicare often include changes in the benefit package. However, such changes are sometimes viewed as a means for generating savings for the Medicare program. Since Medicare only covers a little over half of the health care expenses of the enrollee population and most beneficiaries are spending a rising share of their incomes each year on health care, it is difficult to "improve" the benefit package for beneficiaries in a way that saves costs. Unless additional taxpayer dollars are put into the program, few would benefit from such changes.

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For example, even the commitment of $300 billion over ten years for a prescription drug benefit will cover only about 23 percent of the spending that is expected by beneficiaries on drugs over the next ten years. It is simply not possible to satisfy demands for a good drug benefit without more resources than what has been allocated at present. Beneficiaries will be very disappointed with this level of spending since it will do little to protect them from high out-of-pocket costs in the future. If drug spending costs grow at 10 percent per year, beneficiaries will face expenses of nearly $4500 by 2010. Private supplemental coverage is not adequate and likely will deteriorate as employers and HMOs pull back their drug coverage and Medigap premiums become prohibitively expensive. Further, beneficiaries' incomes will grow at a rate much less than 10 percent each year, causing them to devote an ever higher share of income to drug expenses.

Adding prescription drug coverage to Medicare offers an opportunity to finally improve the overall benefit package, but this would increase taxpayer costs. From society's standpoint, care would be delivered more efficiently, but the public burden would rise. Any such plan likely needs to offer stop loss, keep the deductibles from becoming a barrier to care, and avoid changes that would burden the sickest beneficiaries. In particular:

* A combined A/B Medicare deductible would result in many people facing higher costs. While persons hospitalized would benefit from a combined deductible of $500, for example, five out of every six beneficiaries would not. Inattention to affordability issues may create problems with access to care. A high deductible on physician services, for example, may discourage some beneficiaries from getting needed care in a timely manner.

* It is probably simpler to retain two deductibles, adjusting their relative levels, than to combine them. This is consistent with the practices of many private plans, including those in FEHBP. The burden from the hospital deductible could be reduced and the Part B deductible increased without creating as much of an imbalance between those who have no hospital stay and those who do.

* Any change in the benefit package to eliminate the need for Medigap coverage is not feasible unless it contains stop loss protections -- that is, a guaranteed amount above which the government (and not the individual) pays for any additional cost sharing. The problem with stop loss has always been that when it is low enough to be attractive, it becomes very expensive. For example, many private plans have $2000 or $2500 limits on out-of-pocket expenses. Under Medicare, a less costly limit of $4000 would probably not get many people to forego other insurance.

* If cost sharing is added to home health or to the early parts of a hospital or skilled nursing stay as some have suggested, costs would rise substantially for the sickest and poorest beneficiaries.

* High option/low option approaches could leave many moderate income individuals in the low option plan if the premiums are high for a better benefit package. This would largely defeat the purpose of offering an improved benefit package. Particularly if drugs are only in the high option portion, this approach

would likely lead to risk selection (in which individuals with high drug expenses disproportionately enroll in the high option plans)and other problems for creating a well run program. As an essential part of the treatment of health care, drugs are now integral to care and should be part of a basic benefit package. Would we consider a low option plan that excluded hospitalization, for example?

* Low income protections need to be expanded and perhaps moved into Medicare itself if premiums go up to add drugs to the benefit package.

Finally, another important issue relating to the goal of improving benefit coverage is whether such changes will or should be held hostage to other changes in Medicare. Good care either in fee-for-service Medicare or under private plan options requires comprehensive coverage of essential health care goods and services. This includes prescription drugs. It does not matter what shape reform takes, the need for improved coverage will still be there. And, in fact, adding drug coverage is a necessary element to reduce risk selection problems and to allow better management and coordination of care.

Restructuring the Program to Add More Insurance Options

This issue incorporates the third and fourth principles offered by the Bush administration. The third principle is a promise extended only to persons above a certain age that the traditional program would remain as an option. Presumably this means no improvements in the benefit structure such as those described above; such improvements would only be available to those in private plans and perhaps to beneficiaries paying a substantially higher premium for a high option fee-for-service benefit. Over time, the principles imply that traditional Medicare benefit would be eliminated. The fourth principle promises more options like those available to Federal employees. Together, this suggests major emphasis on a premium support or a managed competition approach with a much larger role for private plans.

Health care analysts have long raised the potential benefits of encouraging coordination and flexibility of care in a capitated setting, giving plans incentives to find the least expensive ways to deliver care within a budget. In theory, this should reduce the overuse of services associated with fee-for-service medicine and offer opportunities to insurers to try out new approaches. And, if there is price competition, economic theory would suggest that this will keep the pressure on plans to be attractive to potential enrollees, increasing their market share and delivering care efficiently.

But in practice, will this really mean an improvement in health care for Medicare beneficiaries? In Medicare, FEHBP, and private insurance in general, problems with managed care and the market for insurance cast doubts on how well such a system would work. In Medicare, for example, such plans fail to save the federal government any money because of the cream skimming of low cost beneficiaries. Nonetheless, plans have engaged in many activities that put beneficiaries at risk. Supporters of private options often put the blame for problems with Medicare+Choice on HCFA's management. The problems facing Medicare+Choice have a complex set of causes, but cannot be explained away only by poor management by government.

Plans are attractive to beneficiaries because they offer additional services. In fact, the ads that many plans run suggest the importance of vision, dental and drug coverage and mention only in small type that care must be received in network. Since plans have received payments higher than necessary for Medicare-covered services and because they may be providing those services at lower costs, they have been able to subsidize their offerings of additional benefits. But, over the last three years, these extra benefits have been substantially reduced in many plans. For example drug coverage has declined from 84.3 percent in 1999 to 70 percent having such coverage in 2001. Withdrawals have left a number of beneficiaries scrambling to enroll elsewhere or to get Medigap coverage if they return to traditional Medicare. And when drug coverage has been retained, stringent caps have been applied or substantial premiums levied on the beneficiary. The cross-subsidy for these extra services has been reduced. Plans and beneficiaries have come to depend upon subsidies not available to those in traditional Medicare, creating troubling inequities.

In addition, beneficiaries have not been treated well by some of the private plans. Private plans have sometimes sought to save costs by limiting access to new technology, to exclude from their plans sub-specialists with considerable experience in treating certain types
of illnesses, and to put in place other barriers to getting care. If done carefully and with appropriate medical practice in mind, these methods may be a successful way of holding down costs. But, many researchers have concluded that these are sometimes arbitrary or problematic barriers. The "flexibility" available to plans can be problematic and that at least in some cases, patients do not have access to all Medicare-covered services. Ironically, these examples illustrate denial of "choice" in a form that is likely to be of more importance to beneficiaries than what is often touted as an advantage of private plans offering "choice."

The organizations that contract with Medicare to provide counseling and information or who run specific hotlines for Medicare beneficiaries often find a disturbing pattern of denials of care. Plans routinely deny claims that have minor errors, with no explanation to beneficiaries. But most important, when people are sick, and least able to battle the system, arbitrary rules and the "flexibility" that plans utilize can result in egregious cases of denials. Plans are supposed to cover all Medicare-covered services, but clients of the Medicare Rights Center, which runs a national HMO hotline, have included people denied a type of cancer treatment specifically approved via a national Medicare coverage determination, for example. Others are sent to physicians only barely qualified to provide specialty care.

In many ways, the Medicare+Choice benefit has been one of the less successful changes that have occurred in Medicare. Despite payments that should be sufficient to compensate plans for the costs of Medicare-covered services, the number of withdrawals of plans and cutbacks in services for those who remain reached a peak at the end of 2000. The resulting disruptions for beneficiaries have been problematic. At present, the program is neither saving money for the federal government nor achieving good, stable care for many of its enrollees. Private plans certainly have a role to play in Medicare, but

many of the issues described above need to be resolved and the current program needs to be working well for beneficiaries before greater reliance is put on private plans under Medicare. The problems go well beyond government management issues.

Strengthening the Program's Finances

Assuring Medicare's viability into the future is extremely important. But the Bush administration set off on a misleading track in its budget submission that suggested that general revenue financing is not a legitimate source of funding for Medicare. This is despite the fact that such financing has been authorized in statute since 1965. Suggestions to combine Parts A and B of the program to generate a new test of solvency effectively use the existence of a trust fund as a means for controlling the costs of the program rather than of protecting it.

If there is a national commitment to Medicare and its future, the level of funding and support needs to be determined on the basis of what is needed to provide reasonable benefits to those eligible for the program. Broader views of financing and solvency are needed in the debate on Medicare' s future. According to the dictionary, a program is solvent if it is "capable of meeting financial obligations." If as a society we decide to support the Medicare program, we have the capability of doing so. Hard choices will need to be made about what we want to support as a society, but a new measure of solvency is not helpful unless it realistically balances goals and resources. This cannot be funded out of fraud and abuse reductions, nor from "efficiencies" from the private sector. To serve one in every five Americans in 2025 will require a substantial commitment of resources.

Management and Regulatory Issues

The last three principles on the Bush administration's list refer to the appropriate oversight and administration of the program. Although the principles do not raise the issue of resources for such improvements, that discussion is at the heart of the issue. In the 1990s, Medicare became a much more complex program. The private plan option grew substantially so that essentially the Health Care Financing Administration had to oversee two very different types of Medicare programs. It did so in an environment of increased responsibilities beyond Medicare (i.e. SCHIP and HIPAA), of essentially no new resources, and of considerable hostility. In that context, it would have been surprising had HCFA been able to meet the unreasonable expectations placed on it.

A new administration offers opportunities for reviewing old practices and taking a different tack in a number of areas. Improved management would be welcome for the program from all quarters, but the expectations need to be reasonable. Better information for consumers, measurement of quality, new innovations and demonstrations for improvements in coverage, greater use of the market where appropriate, and adding private sector expertise to the agency will require substantial additional financial resources, more operating flexibility, and de-politicization of an agency that needs to be efficiently run and serve its customers well.

Another major area of concern has been regulatory burdens on plans and providers. But how many regulations are enough? What areas require the most oversight? While it is tempting to throw the current system out and start over again, many regulations continue to be needed to protect beneficiaries. Two types of regulation and oversight are essential: assurances that quality care is being delivered and that beneficiaries have adequate protections for assuring access to covered services. A careful review of existing regulations and requirements should closely examine whether there are *enough* protections for beneficiaries. Particularly if beneficiaries are locked into private plans by future reforms, the need for oversight will be considerable if abuses now occurring in Medicare+Choice are to be avoided. If beneficiaries are going to be asked to take greater responsibility for care, it is important to have in place appropriate protections and controls for those who are cognitively impaired, frail, non-English speaking, or face other barriers to their getting care. This is a substantially larger group than found in younger populations. In that way, Medicare is different and regulatory needs are also different.

Finally, it is important to note that few private insurance companies escape problems of complexity and bureaucracy. Many patients, both young and old, find the requirements of their plans to obtain approval before getting some services, to determine which doctors and hospitals are in network and which are not, to understand the bills when they come due months later, and to use the appeals process to be cumbersome, complex and overly bureaucratic. Thus, problems with the complexity of our current health care system are by no means inherent only to government. So examining reform from the context of Medicare beneficiaries should consider whether more reliance on private plans will only complicate and confuse beneficiaries further. An assumption is often made that using private plans to provide services will ease the government's oversight burdens, but at what expense to beneficiaries?

Conclusion

The principles outlined by the Bush administration for Medicare reform are to some extent in conflict. Improved financial stability, for example, will be harder to obtain if the benefit changes and management improvements described above are made. And there is little evidence to indicate that reliance on the private sector will save government costs (unless substantial burdens are passed on to beneficiaries). Thus, the first task in fleshing out these principles should be for the administration to indicate its priorities and make clear how much in the way of further resources will be available for improvements.

A broad range of changes in Medicare will be needed in the future to improve the program. But no set of reforms can be expected to run perfectly over time with no adjustments. Medicare's future will likely be rewritten numerous times as health care changes and Baby Boomers move through the system. What is important, however, is to avoid making major structural changes on the basis of theory that may be difficult to undo if the reality falls short of the theory. Beneficiaries are the ones likely to be put at risk in such a situation. Much needs to be done, but improvements in Medicare do not need to be delayed until all the pieces are put into one tidy package.